



MedicareAdvocacy.org

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MEDICARE ADVANTAGE

Se habla español

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WHAT IS MEDICARE ADVANTAGE?

In addition to the government's traditional Medicare program, Medicare offers individuals the option to receive services through a variety of private insurance plans. These private insurance options are part of Medicare Part C and are called Medicare Advantage (MA) plans. MA is a means of receiving health care and Medicare coverage. An individual who joins an MA plan is still in the Medicare program. In most cases, in order to participate in Medicare Advantage an individual must specifically opt to receive Medicare coverage through an MA plan. Once this choice is made, the individual must generally receive all of his or her care through the plan's providers in order to receive Medicare coverage. One of the main goals of MA plans is to manage health care in order to reduce costs while also providing necessary care.

With some exceptions, an MA plan must provide or pay for medically necessary Part A and Part B covered items and services. In addition to providing traditional Medicare benefits, the MA plan may also provide and pay for supplemental benefits (benefits not covered under Part A or Part B) and prescription drug benefits. Many MA plans also include Part D prescription drug coverage. These plans are known as Medicare Advantage Prescription Drug plans or MA-PDs.

MA plans differ with respect to what benefits they provide above and beyond the traditional Medicare benefits they are required to provide, out-of-pocket costs such as premiums, deductibles, and co-pays, doctor and hospital choice, and whether they provide prescription drug coverage. It is important to remember that individuals do not have to change the way they currently access their Medicare benefits, whether they are in traditional Medicare or an MA plan. An individual with coverage through their current or former employer should check to see how any changes might affect such coverage.

WHO IS ELIGIBLE FOR MEDICARE ADVANTAGE

An individual entitled to benefits under Part A *and* enrolled in Part B is eligible for an MA plan. An individual is eligible to enroll in a particular MA plan if the plan serves the geographic area in which the individual resides. An MA plan may not deny enrollment to an eligible individual based upon health status or certain other factors. However, currently individuals with end-stage renal disease (ESRD) are excluded, except that an individual who develops ESRD while enrolled in an MA plan may continue to be enrolled in that plan. Such an individual may also enroll in another MA plan if the individual's original plan terminates its contract with CMS or reduces its service area. An individual with ESRD may, however, elect an MA special needs plan as long as that plan has opted to enroll ESRD individuals. There are also circumstances where an MA organization may accept enrollees with ESRD who are enrolling in an MA plan through an employer or union group. The 21st Century Cures Act removes the barrier for people with ESRD to enroll in MA plans beginning in 2021.

WHAT OPTIONS ARE AVAILABLE UNDER MEDICARE ADVANTAGE?

There are three basic types of MA plans. Depending on where an individual lives, not every type of plan might be available to them.

- **Coordinated Care Plans** These plans include the following:
 - Health Maintenance Organizations (HMOs)
 - Preferred Provider Organizations (PPOs)
 - Special Needs Plans (SNPs) designed for people who live in certain institutions, are eligible for both Medicare and Medicaid, or have one or more specific chronic or disabling conditions.
- **Medical Savings Account Plans (MSAs)** combine the use of a health care savings account with a high deductible catastrophic health plan.
- **Private Fee-For-Service Plans (PFFSs)** allow an individual to use any doctor or hospital as long as that provider accepts the plan's terms and conditions. Based on other plans available in a given service area, some PFFS plans must establish provider networks.

WHAT YOU PAY

Out-of-pocket costs in an MA plan depend on whether the plan charges a monthly premium, whether the plan has a yearly deductible, how much you pay for each visit or service (copayments or coinsurance), the type of health care services needed and how often and whether network providers are used. MA plans may charge cost-sharing for a service that is above or below the traditional Medicare cost-sharing for that service. However, MA plans cannot impose cost-sharing for chemotherapy administration services, renal dialysis services, and skilled nursing care services that exceed the cost-sharing for those services under traditional Medicare.

All MA plans must have a maximum allowable out-of-pocket (MOOP) limit on the amount of cost-sharing they can charge for all Part A and Part B services, with the amount to be set by CMS on a yearly basis. Currently the maximum allowable MOOP is \$6,700. MA plans can use a lower, voluntary MOOP of \$3,400 in exchange for greater flexibility in establishing cost-sharing amounts

HOW TO JOIN A MEDICARE ADVANTAGE PLAN

To enroll in an MA plan, an individual must complete and sign an election form or complete another CMS approved election method offered by the MA organization. Individuals can contact their plan choice directly or call 1-800-MEDICARE to enroll. At a minimum, MA organizations must have a paper enrollment form process available for potential enrollees.

MEDICARE ADVANTAGE ENROLLMENT PERIODS

An individual is only permitted to join or leave an MA plan at certain times during the year. There are five types of election periods during which an individual may make a Medicare Advantage enrollment request.

The **Initial Coverage Election Period (ICEP)**, the period during which a newly MA eligible individual may make their initial choice to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of either the last day of the month preceding entitlement to both Part A and Part B, or, the last day of the individual's Part B initial enrollment period.

During the **Annual Coordinated Election Period (ACEP)** all MA eligible individuals may elect among all available options, whether traditional Medicare, MA plans, MA-PD plans, or Prescription Drug Plans (PDPs). The ACEP occurs from October 15 through December 7 of every year; coverage begins on the first day of the following calendar year. The Annual Enrollment Period for Part D mirrors that of the ACEP for MA. It is important to note that Medigap does not have an annual enrollment period and Medigap enrollment rights vary from state-to-state.

Open Enrollment Period for Institutionalized Individuals (OEPI). MA eligible individuals, who move into, reside in, or move out of a nursing home or other institution, as defined by the Centers for Medicare & Medicaid Services (CMS), can make an unlimited number of MA elections.

The Medicare Advantage Open Enrollment Period (MA OEP) is only available to those enrolled in an MA plan. During this period those enrolled in an MA plan as of January 1 or new Medicare beneficiaries who are enrolled in an MA plan during their ICEP may enroll in another MA plan or disenroll from their MA plan and return to traditional Medicare. Individuals may also add or drop Part D coverage during the MA OEP. Only one election is allowed during this period and the effective date for election is the first of the month following receipt of the enrollment requests. The MA OEP occurs from January through March 31 for individuals enrolled in an MA plan. For new Medicare beneficiaries who are enrolled in an MA plan during their ICEP the MA OEP occurs the month of entitlement to Part A and Part B – the last day of the 3rd month of entitlement.

SPECIAL ENROLLMENT PERIODS

During a **Special Enrollment Period (SEP)** an individual may elect a plan or change their current plan election. Certain qualifying events can trigger an SEP. There are many different SEPs, including: for changes in residence; for contract violations; for non-renewals or terminations of plans; for beneficiaries age 65; for significant change in provider network; for CMS and state-initiated enrollments; and for individuals who meet “exceptional circumstances” as the Medicare program may provide. At this time CMS has established roughly 18 SEPs for exceptional conditions. The Medicare Managed Care Manual, Chapter 2, Section 30.4 sets forth all 18 SEPs. https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY_2019_MA_Enrollment_and_Disrollment_Guidance.pdf

HOW AND WHEN TO DISENROLL FROM A MEDICARE ADVANTAGE PLAN

An individual may only disenroll from an MA plan during one of the election periods described in this brochure. A beneficiary may disenroll by enrolling in another plan, giving or faxing a signed written notice to the MA organization, by submitting a request via the Internet to the MA organization, or by calling 1-800-MEDICARE. Generally, the date coverage ends will be the first day of the month after an individual requests disenrollment. Retroactive disenrollment may be granted by CMS if there never was a legally valid enrollment, or a valid request for disenrollment was properly made but not processed or acted upon.

CONSIDERATIONS BEFORE JOINING A MEDICARE ADVANTAGE PLAN v. TRADITIONAL MEDICARE

- Compare the coverage and costs available through the traditional Medicare program combined with an appropriate Medigap policy, versus the MA plans available in your geographic area.
- MA plans are not required to provide enrollees the same access to all Medicare providers that is available under traditional Medicare. In most plans enrollees must use providers and facilities in the plan's network. In other plans, enrollees must pay more to see "non-network" providers.
- MA plans can decide each year whether to offer an MA plan and may discontinue the plan after providing their enrollees with notice. MA plans can also change benefits, premiums, copays and their provider network from year to year.
- Many plans require enrollees to obtain the prior approval of their primary care physician in order to see a specialist.
- There may be a limited geographic area where enrollees can receive care.
- Plans only cover emergency and urgent care if an enrollee is out of the service area, but an enrollee must return to the area for follow up or routine care.
- It can take up to 30 days to disenroll, and an enrollee must continue to use the MA plan during this time.
- MA plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in traditional Medicare.

CONSIDERATIONS WHEN SELECTING A MEDICARE ADVANTAGE PLAN

- Find out whether, and to what extent, you are required to receive services from medical providers who participate in the MA plan you are considering. If so, are the doctors and other health care providers, hospitals and other facilities from whom you would want to receive care available to you in the plan?
- Read each plan's literature to see what kind of plan it is and what it pays for. Review the Evidence of Coverage, Summary of Benefits, and the Annual Notice of Change that notifies enrollees of cost and benefit changes that will take effect starting January 1st of the following year.
- Does the plan include Part D prescription drug coverage? If not, do you want to join a separate Part D plan?
- Determine what plan services are provided at additional cost. All preventive services should be identified, as well as any limitations associated with visits or services. Determine where you would go for emergency, urgently needed, and regular care.
- Check into the plan's physicians to determine if your physicians are in the plan and find out how to change physicians if a satisfactory relationship with a plan physician cannot be established. In addition, ask which hospitals, skilled nursing facilities and home care agencies the plan contracts with to ensure that there are satisfactory choices.
- Learn how to use the plan's complaint system and how appeals and grievances are handled.
- Ask a plan representative if member satisfaction surveys are conducted and if the results are available for review.
- Contact Medicare's Regional Office to determine if a plan has always complied with Medicare regulations.
- While you can leave your Medicare Advantage plan and return to traditional Medicare on an annual basis, you might not have a right to purchase a Medigap policy, depending on the state you live in and how long you were in the Medicare Advantage plan.

Individuals throughout the country can obtain help and a list of MA plans in their area from their State Health Insurance Assistance Program (SHIP), the Medicare information line, 1(800)MEDICARE, (1-800-633-4227), or the Medicare website (www.Medicare.gov).

In Connecticut contact CHOICES at 1-800-994-9422.

CENTER FOR MEDICARE ADVOCACY

The Center for Medicare Advocacy, founded in 1986, is a national non-profit law organization that works to ensure fair access to Medicare and quality health care. The Center is based in Connecticut and Washington, DC, with offices around the country.

Based on our work with real people, the Center advocates for policies and systemic change that will benefit all those in need of health care coverage and services.

Staffed by attorneys, legal assistants, nurses, and information management experts, the organization represents thousands of individuals in appeals of Medicare denials. The work of the Center also includes responding to over 7,000 calls and emails annually from older adults, people with disabilities, and their families, and partnering with CHOICES, the Connecticut State health insurance program (SHIP).

Only through advocacy and education can older people and people with disabilities be assured that Medicare and health care are provided fairly:

- We offer education and consulting services to help others advance the rights of older and disabled people and to provide quality health care.
- We draw upon our direct experience with thousands of Medicare beneficiaries to educate policy-makers about how their decisions play out in the lives of real people.

The Center for Medicare Advocacy is the most experienced organization for Medicare beneficiaries and their families.

Visit our website:
MedicareAdvocacy.org